STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	07/06/2011

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ZIONSVILLE MEADOWS	675 S FORD RD ZIONSVILLE, IN46077

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 28, 29, 30, July 1, 5 and 6, 2011 Facility number: 000538 Provider number: 155620 AIM number: 100267290 Survey team: Rita Mullen, RN, TC Janet Stanton, RN Michelle Hosteter, RN (June 28, 29 and 30, 2011) Linda Campbell, RN (June 30 and July 1, 2011) Heather Lay, RN (July 5 and 6, 2011) Census bed type: SNF: 13 SNF/NF: 156 Residential: 67 Total: 236 Census payor type: Medicare: 16 Medicaid: 120 Other: 100 Total: 236 Certified sample: 26	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Residential sample: 7 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 7/12/11 Cathy Emswiller RN			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review and interview, the facility failed to ensure a wheelchair pull pin alarm was placed for a Resident with a history of falls. This impacted 1 of 6 Residents reviewed for falls in a sample of 26. (Resident #108) Findings include: The clinical record of Resident #108 was reviewed on 6/27/11 at 9:15 A.M. Diagnoses for Resident #108 included, but were not limited to, depression, dementia, arthritis and high blood	F0282	**F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** This provider ensures the services provided or arranged by the facility are provided by qualified persons in accordance with each resident's written plan of care. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident # 108: the resident's plan of care was reviewed by the Interdisciplinary Team. The resident's care plan and resident	07/26/2011

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	pressure. A Treatment Administration Record (TAR), dated for the month of June 2011, indicated "Resident to have pull pin alarm in w/c (wheelchair), check placement and function every shift." A Care Plan, dated 1/1/11, indicated "[name of Resident] is a risk for fall due to debility, poor safety awareness....a history of falls and attempting to transfer self without requesting assistance...." Approaches included, but were not limited to: Personal items in reach, pull pin alarm on chair to alert staff when resident is attempting to get up unassisted, and an update , 3/19/11, pull pin alarm string shortened. During an observation, on 6/29/11 at 10:45 A.M., Resident #108 was sitting in her wheelchair in the common area without a pull pin alarm on the wheelchair. The pull pin was laying on Resident #108's dresser in her room. During an interview with LPN #6, on 6/29/11 at 1:30 P.M., it was indicated the pull pin was not discontinued and should have been on Resident #108's wheelchair. 3.1-35(g)(2)		care sheet were updated, as needed. The resident's personal alarm is checked by nursing assistants and licensed nurses each shift to monitor compliance. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents with personal alarms have the potential to be affected by the alleged deficient practice. Residents with orders for personal alarms were reviewed by the Interdisciplinary Team to ensure the intervention was appropriate. The physician was notified, as needed, and physician orders, the care plan and resident need sheet were updated, as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff were re-educated on fall interventions and the use of assistive devices, including alarms on July 19, 2011, and ongoing, by the Staff Development Coordinator, or designee. Nursing employees were	

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			re-educated on specific resident needs related to alarms during unit meetings on July 22, 2011, and ongoing through updated resident need sheets. The Interdisciplinary Team reviews resident falls the next business day to determine appropriate interventions to prevent further falls and prevent injuries. The residents plan of care and resident need sheet are updated, as needed. Nursing and department supervisors monitor residents to ensure assistive devices are present per the plan of care. Charge nurses are provided feedback, as needed. The Director of Nursing Services is responsible for compliance with resident alarms. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A CQI tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, to monitor compliance with the placement of alarms. The audits will be reviewed by the CQI committee and action plans will be developed, as needed, to improve compliance.	

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			Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination. **Completion Date: 7/26/11**	
F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. A. Based on record review and interview, the facility failed to ensure that the Therapy Department Manager provided training related to the application of moist hot packs, and failed to visually supervise, 1 of 1 therapy employees who was identified as a "new graduate" as a Certified Occupational Therapy Assistant [COTA]. This deficient practice impacted 1 of 1 residents who sustained trauma identified as a full thickness burn from a moist hot pack which the untrained COTA had applied incorrectly; in a sample of 26 residents reviewed. [Resident # 21] B. Based on record review and interview, the facility failed to ensure that there was sufficient staffing on the Cottage 2 secured Alzheimer's unit to supervise residents at an evening meal. This deficient practice impacted 1 of 1 residents who received scratches and a laceration during a physical altercation with another resident on the unit, for 1 of	F0323	**F 323** **FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES** **It is the practice of this provider to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** **Resident # 21: The resident's skin is intact and the resident does not have pain related to prior impaired skin integrity.** **Resident # 171: The resident no longer resides in the facility.** **Dementia Units: Sharp equipment and hazardous creams and lotions are kept in a safe and secure manner.** **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** **Residents receiving hot pack treatments, and residents residing on the dementia units have the potential to be affected by the alleged deficient practice.**	07/26/2011

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	6 residents reviewed in a sample of 26 residents. [Resident #171]. C. Based on observation and interview, the facility failed to keep sharp equipment and hazardous creams and lotions in a safe and secure manner, on 1 of 2 locked/secured Alzheimer's units. This deficiency had the potential to impact 22 residents residing on this unit. Findings include: A.1. Pre-survey information related to incidents/accidents, which had been reported by the facility to the Long Term Care Division, Indiana State Department of Health since the last annual on 5/21/10, was reviewed on 6/27/11. One incident submitted by the facility on 9/01/10 indicated "Resident [Resident #21] noted to have open area to mid back right side from trauma. Resident states therapy has been applying moist heat every morning. Resident denies pain to area. Resident alert and oriented X 3 [person, place and time].... Area to mid (R) back measuring 10.3 X 3.6 X 0 CM. Wound bed noted to be 50% dermis and 50% epithelial tissue with scattered fluid filled blisters.... Employee suspended pending outcome of investigation." The clinical record for Resident #21 was		**Therapist are provided job specific orientation upon hire and are overseen by the therapy manager. Dementia unit staffing is determined by the census and resident needs to assist with monitoring supervision to prevent injuries.** **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** **Staff were re-educated on the use of assistive devices, hazardous items, and the monitoring of residents during survey on June 29 and 30th, 2011, and on July 19, 2011, and ongoing, by the Staff Development Coordinator, or designee.** **Nursing employees were re-educated on assistive devices, hazards, and monitoring specific units during unit meetings on July 22, 2011, and ongoing through updated resident need sheets and 1:1 inservicing.** **Therapists are provided job specific orientation related to heat packs upon hire. The therapy director monitors compliance with the use of heat packs. Therapy disciplines have specific skills validations completed upon hire and when needed. All therapy employee files were audited to ensure all skills validations for specific modalities and complete job orientations were completed**	

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	reviewed on 7/05/11. Diagnoses included, but were not limited to, anemia, hypokalemia, constipation, hypertension, stage IV sacral ulcer, and coronary artery disease. A "Nurse's Notes" progress note, dated 8/31/10 at 5:30 A.M., indicated "Open area noted to right side of back. No pain noted from site. Resident stated that heat has been applied to his back from therapy in the mornings. Site looks like a blister that had busted. Area was cleaned with NS [normal saline]. Telfa applied and covered with Coverall. M.D. was notified along with wound team." An I.D.T. [Interdisciplinary Team] progress note on 8/31/10 indicated "Weekly skin note: Resident is being reviewed in I.D.T. for open area to coccyx and mid right back.... Mid back right side trauma partial thickness wound measures 10.3 X 3.6 X 0 cm. [centimeter].... Resident states he received moist heat therapy the previous day in therapy." On 7/5/11, the Executive Director provided the documentation of the facility's investigation of the reported incident. The documentation included a paper titled "Interview 8/31," "Employee Communication Form," "Performance Improvement Plan," "Therapy Department		**on July 22, 2011.** **Activity staffing was adjusted on May 1, 2011, to provide additional supervision on the evening shift.** **The dementia unit environment and resident safety is monitored each shift through environmental rounds that are completed by housekeeping, activity and nursing staff.** **Nursing and department supervisors monitor residents to ensure assistive devices are present per the plan of care, and the environment is free of hazards. Charge nurses are provided feedback, as needed.** **The Director of Nursing Services is responsible for compliance with assistive devices and hazards.** **The Director of Therapy is responsible for compliance with heat pack therapy and providing orientation and ongoing training to therapy staff.** **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** □A CQI tool will be utilized weekly x 4, monthly x 2 and quarterly thereafter, to monitor compliance with the application of heat packs, assistive devices, and environmental hazards. All	

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	Orientation," "Cold Pack/Ice Pack Competency Checklist," and "Moist Hot Pack Competency Checklist." The "Interview" paper indicated that Therapy Assistant #7 did not have training on the application of moist heat packs, was "never supervised with heat," and had "not read therapy policy manual." The interview also indicated "they" ran out of towels so used 2 bath blankets on each side of the moist hot pack plus the cover, and that the Therapy Assistant "did not do visual check on the skin, but did ask the resident and he said he was fine." The "Interview" paper indicated the Therapy Manager "stayed with the resident during the treatment and asked if it was too warm, but did not visually check the skin." The hot moist pack treatment lasted 15 minutes. The "Employee Communication Form," dated 9/1/10, indicated "Manager did not ensure new staff orientation completed on at least 2 new employees. One incident resulted in harm to resident." The "Therapy Department Orientation" form, a "Cold Pack/Ice Pack Competency Checklist," and a "Moist Hot Pack Competency Checklist" for Therapy Assistant #7 was dated as completed on 9/1/10.		therapy employee charts will be audited within 2 weeks after hire by HR and results will be reported to the QA committee. The audits will be reviewed by the CQI committee and action plans will be developed, as needed, to improve compliance. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination.	

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	A Policy/Procedure titled "Moist Hot Packs Competency," dated as revised on 12/09, included, but was not limited to, the following information: "POLICY: All clinicians who perform the hot moist pack modality will complete a skills validation checklist within 90 days of their hire date.... PROCEDURE: 1. Upon hiring, or as determined by the Rehab Services Manager or supervising therapist, each clinician that is going to perform moist hot packs will be assigned to another clinician whose skills have been validated to complete his/her skills validation checklist.... 2. The observing clinician will observe the clinician who is being tested perform the specific procedure.... 13. At five minutes after the initial application of the hot pack, the patient's skin should be checked for redness or blanching to touch, in which case, more towels should be added.... 15. Hot moist packs must be checked every 5 minutes for the duration of the treatment...." In an interview on 7/5/11 at 4:00 P.M., the Executive Director indicated there were no therapy records on Resident # 21 regarding moist hot pack application.			

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	In an interview on 7/6/11 at 11:05 A.M., the Assistant Rehabilitation Manager #9 and Rehabilitation Manager #10 indicated therapy progress notes on moist hot pack application were normally kept in a resident's record. However, no records existed for the hot pack application done in August, 2010 for Resident #21. They indicated the orientation policy and procedure had changed since the incident, and required new employees to have skills checked off by the Rehabilitation Manager by the third day of employment. The Rehab Manager included visually observing a new employee demonstrate the skills. A therapy-specific orientation had also been implemented following the incident. B.1. The closed clinical record of Resident #171 was reviewed on 7/6/11 at 10:30 A.M. Diagnoses for Resident #171 included, but were not limited to history of right frontal brain hemorrhage, vascular dementia, osteoarthritis and high blood pressure. A quarterly minimum data set assessment, dated 12/23/10, indicated Resident #171 had severely impaired decision making skills. A Plan of Care, dated 11/6/10, indicated			

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	"Res [Resident] will get into peers rooms if he is not taken to his room & assisted to his bed. Risk for harm." Interventions: " 1. Assist res to his room after each meal or event. 2. Gently redirect from peers room when redirected." A Plan of Care, dated 11/6/10, indicated "Resident is at risk for falls d/t [due to] debility, poor safety awareness..." Interventions included, but were not limited to, chair alarm to alert staff of attempts to transfer unassisted and offer to place res in recliner [after] meals if attempting to self transfer...." A Treatment Administration Record, dated for the month of January 2011, indicated "Chair alarm sensor to wheelchair and recliner at all times while in recliner or wheelchair..." A nursing note, dated 1/4/11 at 7:10 P.M., indicated "Resident was found on floor in another Resident's room....Resident [#171] had been in another resident's bed. The other Resident involved stated he hit the resident in the face [with] his fist et [and] shoe....Neither resident knew how [name of Resident #171] got on the floor....The other resident was put on 1:1 supervision...." During an interview with the unit			

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	manager, LPN #5, on 7/6/11 at 12:15 P.M., indicated staffing for evening shift was 2 CNAs and 1 LPN. Dinner was late that evening and no staff member was in the dining room. CNA #13 was assisting to toilet a Resident, CNA #12 was assisting a new Resident and LPN #12 was escorting a Resident upstairs to visit with their spouse. CNA #13 was on her way back to the dining room heard an alarm, going off, in Resident #170's room and found Resident #171 on the floor with Resident #170 standing over Resident #171 with a shoe in his hand. Resident #171 had left the dining room, while it was unattended by staff, and entered Resident #170's room and got into Resident #170's bed. No staff member heard Resident #171's wheelchair alarm sound when he transferred himself to Resident #170's bed. C.1. During the environmental tour on 6/29/11 at 2:00 P.M. with the Maintenance Manager and the Housekeeping Supervisor, in the kitchenette area in the drawers which were not locked and in the drawers were disposable razors and a nose hair trimmer. The shower room for the unit was found to be unlocked and in an unlocked cabinet there was found to be the following items; one bottle of deodorant, one .85 ounce			

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	tube of toothpaste, one 5 ounce tube of Provon perineal skin creme, one 1/8 ounce Calmoseptine packet, and one bottle of Quat disinfectant with a small approximately 1 ounce of liquid in it. At 2:05 P.M. in a hallway off of resident rooms which was not in visible site of nursing station or staff, a dresser was found unlocked with the following items in it; two 1/8 ounce packets of Calmoseptine ointment, one 5 ounce tube of Provon perineal skin creme. The warning label on the Calmoseptine indicated to keep out of reach of children and avoid contact with eyes. The warning for the Quat disinfectant indicated harmful if swallowed, avoid contact with eyes and keep out of reach of children. The warning for the Provon creme indicated to avoid contact with eyes. In an interview with the Housekeeping Supervisor and the Maintenance Manager immediately following the tour, the Maintenance Manager indicated the bathroom door should have been shut and locked and they do not secure the lock on the cabinet in the bathroom due to having a lock on the door. He also indicated the nose hair trimmers and disposable razors don't belong in the kitchenette area, he stated he would be sure to secure items.			

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	The housekeeping supervisor indicated the barrier creams and razors should not be kept in the unlocked dresser in the hallway by residents rooms. 3.1-45(a)(1)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to ensure the oven was free of debris in the oven for 1 of 2 ovens in 1 of 1 kitchens. This had the potential to effect 162 residents out of 168 who received meals from the kitchen oven. Findings: During the kitchen tour on 6/27/11 at 10:20 A.M. the convection oven there was a large amount of black greasy debris on the bottom of the oven and surrounding the door frame of oven. The Dietary Manager indicated that this is the only oven that they cook in and that it is on their cleaning schedule.	F0371	**F 371 FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY** This provider ensures the facility: (1) Procures food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to be affected by the alleged deficient practice.	07/26/2011

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Dietary Manger provided a cleaning schedule for the oven upon request on 6/27/11 at 11:50 A.M. The schedule was titled "Daily Cleaning Schedule" and was broken into tasks. The task marked interior and exterior of top of oven and was marked through and the dietary manager indicated this means it has been completed. She also indicated that the kitchen staff rotates the duties so not just one staff member is responsible for cleaning the same area every day. 3.1-21(i)(2)		The oven was cleaned upon cooling per manufacturers guidelines. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? Residents receiving facility prepared meals have the potential to be affected by the alleged deficient practice. The oven is cleaned daily per the cleaning schedule and manufacturer's guidelines. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** The RD will check the oven upon weekly visits and upon monthly sanitation review of the kitchen. All dietary staff were inserviced on cleaning the oven June 30, 2011. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** A CQI tool will be utilized weekly x	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155620	A. BUILDING 00 B. WING	07/06/2011

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			4, monthly x 2 and quarterly thereafter, to monitor compliance with the oven cleaning. The audits will be reviewed by the CQI committee and action plans will be developed, as needed, to improve compliance. Noncompliance with facility policy and procedure may result in employee education and/or disciplinary action up to and including termination. **Completion Date: 7/26/11**	
R0000	This State Residential finding is cited in accordance with 410 IAC 16.2-5.	R0000		

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to have the Service Plans for 2 of 2 residents living on the Cottage I Residential-licensed secured/locked Alzheimer's unit signed by the resident and/or the legally responsible party. This deficiency impacted 2 Residential residents in a sample of 7 reviewed. [Residents #173 and #174]	R0217	R217 **What corrective action will be accomplished for those found to have been affected?** Resident #173 and #174 : Service plans will be completed and placed in the clinical record. Service Plans will be reviewed and agreed upon by the legal representative or responsible party **How the facility will identify**	07/26/2011

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	Findings include: The clinical record for Resident #173 was reviewed on 6/29/11 at 10:25 A.M. The clinical record for Resident #174 was reviewed on 6/29/11 at 10:58 A.M. Service Plans were not found for either resident. In an interview on 6/30/11 at 9:50 A.M., the Administrator indicated the "Resident Care/Need Sheet" forms were used on the Cottage I Alzheimer's unit as the Service Plan. A copy of the "Resident Care/Need Sheet" form, dated 6/29/11, was provided for review. Multiple residents were addressed on the front and reverse sides of the form--6 on the front and 8 on the reverse side of Page 1; 4 on the front of Page 2; and 3 on the front of Page 3. The forms listed the care to be provided for showers, A.D.L. [Activity of Daily Living] care, toileting, mobility, activities, equipment and devices, behaviors, and any other special needs. The frequency the care was to be provided was also listed. There was no section or area available on the multi-listing sheet for a resident or		**other residents having the potential to be affected ?** Audit on all Cottage I residents will be completed to ensure that the service plans are updated and in the clinical record. Facility will make contact with legal representative or responsible party to ensure that they are notified of the services being provided and are in agreement with the services **What measures will be put into place or what systemic changes the facility will make?** Resident service plans will be updated at least semiannually and upon a known substantial change in the resident's condition. Legal representative or responsible party will be contacted and service plans will be reviewed. Administrator /Designee will keep a calendar system to ensure service plans are reviewed and update timely **How the corrective actions will be monitored to ensure the deficient will not reoccur?** Administrator/Designee will complete an audit not less than 25% of resident records over the next three months to ensure systems are current. Inservice will be conducted by Regional Director of Operations on service plans **By what date the systemic changes will be completed?** Completion date July 26, 2011	

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	legal representative to sign indicating the Service Plan had been reviewed and agreed upon by them. In the interview on 6/30/11 at 9:50 A.M., the Administrator indicated she was aware that Service Plans needed to be signed by the resident and/or responsible party.			